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Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

VERMONT OXFORD NETWORK
eNICQ DELIVERY ROOM DEATH BOOKLET FOR INFANTS BORN IN 2020

Use the Delivery Room Death Booklet for eligible inborn infants who die in the delivery room or at any other location in your hospital within 12 hours of birth and prior to admission to the NICU.

This booklet contains protected health care information and must NOT be submitted to Vermont Oxford Network (VON). VON only accepts protected health care information in cases where members have both voluntarily elected to send this information to VON and have signed an appropriate Business Associate Agreement with VON.

This booklet is designed for you to use to collect data that will be later entered by your center into eNICQ, the VON data submission tool.

Contents:

Page 1: Patient Identification Worksheet
Page 2-3: Delivery Room Death Data Items For Infants Born in 2020 at Expanded Centers

DELIVERY ROOM DEATH
PATIENT IDENTIFICATION WORKSHEET

Patient's Name: _____

Mother's Name: _____

Patient's Medical Record Number: _____

Date of Birth: ____/____/____
MM DD YYYY

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

Patient ID number: _____ (this is the VON Network ID – it is auto-generated by eNICQ)

Medical Record Number: _____

Date of Birth: ____/____/____ (MM DD YYYY)

Died in Delivery Room: ☐ Yes ☐ No (If *No*, complete General Data Items booklet, not this booklet)

Patient's First Name: _____

Patient's Last Name: _____

Mother's First Name: _____

Mother's Last Name: _____

Birth Weight: _____ **grams**

Gestational Age, Weeks: _____ **Gestational Age, Days (0-6):** _____

Head Circumference at Birth (in cm to nearest 10th): ☐☐.☐

Maternal Ethnicity/Race (Answer both Ethnicity and Race):

Ethnicity of Mother: ☐ Hispanic ☐ Not Hispanic

Race of Mother: ☐ Black or African American ☐ White ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Prenatal Care: ☐ Yes ☐ No

Antenatal Steroids: ☐ Yes ☐ No

Antenatal Magnesium Sulfate: ☐ Yes ☐ No

Chorioamnionitis: ☐ Yes ☐ No

Maternal Hypertension, Chronic or Pregnancy-Induced: ☐ Yes ☐ No

Maternal Diabetes ☐ Yes ☐ No

Mode of Delivery: ☐ Vaginal ☐ Cesarean Section

Sex of Infant: ☐ Male ☐ Female ☐ Unknown

Multiple Gestation: ☐ Yes ☐ No **If *Yes*, Number of Infants Delivered:** ____

Congenital Infection: ☐ Yes ☐ No

Congenital Infection, Organism(s): _____ _____ _____
(If *Congenital Infection* is *Yes*, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)

APGAR Scores: **1 minute** _____ **5 minutes** _____

DRD Data Items - *For Infants Born in 2020 at Expanded Centers* VON Vermont Oxford NETWORK

Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

Initial Resuscitation:

Oxygen:	☐ Yes	☐ No
Face Mask Vent:	☐ Yes	☐ No
Laryngeal Mask Airway:	☐ Yes	☐ No
Endotracheal Tube Vent:	☐ Yes	☐ No
Epinephrine:	☐ Yes	☐ No
Cardiac Compression:	☐ Yes	☐ No
Nasal Vent:	☐ Yes	☐ No
Nasal CPAP:	☐ Yes	☐ No

Surfactant during Initial Resuscitation: ☐ Yes ☐ No

Surfactant at Any Time: ☐ Yes ☐ No (*Surfactant at Any Time* must be *Yes* if *Surfactant During Initial Resuscitation* is *Yes*)

If *Yes*, Age at First Dose of Surfactant: Hours _____ Minutes (0-59) _____

Congenital Anomaly: ☐ Yes ☐ No

If *Yes*, enter up to 5 Congenital Anomaly Codes: _____ _____ _____ _____ _____
See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.

If *Yes*, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, & 907:

_____

_____

Meconium Aspiration Syndrome: ☐ Yes ☐ No **(for infants where Meconium Aspiration Syndrome is *No*, infant record is now complete)**

If Yes, Tracheal Suction for Meconium Attempted during Initial Resuscitation: ☐ Yes ☐ No **(infant record is now complete)**